BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
KENT S. TAYLOR, M.D. 131 Crespi Exeter, CA 93221 License No. A-11265	NO. D-2113 N-10814
Respondent.	

DECISION AND ORDER

The proposed decision in this case was initially not adopted by the Division of Medical Quality. Following non-adoption, the Division then proceeded to decide the case itself upon the record, including the transcript. The opportunity to file written arguments with the Division were afforded the parties.

Having considered the evidence and the arguments, the Division now makes the following decision and order:

The attached proposed decision of the panel of the 9th District Medical Quality Review Committee is hereby adopted by the Division as its decision, the same being incorporated herein by reference as if set forth at length herein, with said proposed decision being adopted in its entirety except for the proposed penalty order which is not adopted but deleted and substituted by the following penalty order made by the Division itself:

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A-11265 issued to respondent Kent S. Taylor, M.D. is revoked pursuant to Determination of Issues III, IV, V, and VI, separately and for all of them.

However, revocation is stayed and respondent is placed on probation for fifteen (15) years upon the following terms and conditions:

1. Within 60 days of the effective date of this decision, respondent shall take and pass an oral clinical examination in Family Practice to be administered by the Division or its designee. If respondent fails this examination, respondent must wait three months between re-examinations, except that after three failures respondent must wait one year to take each necessary re-examination thereafter. The Division shall pay the cost of the first examination and respondent shall pay the costs of any subsequent examinations.

Respondent shall not engage in the practice of medicine until respondent has passed this oral clinical examination and has been so notified by the Division in writing.

2. Respondent shall not practice obstetrics and shall not practice surgery.

3. Respondent is prohibited from engaging in solo practice. Within 60 days of the effective date of this decision, respondent shall submit to the Division and receive its prior approval for a plan of practice limited to a supervised, structured environment in which respondent's activities will be overseen and supervised by another physician.

4. Respondent shall take a refresher course in Family Practice on an annual basis, and shall submit each such course in advance to the Division for its prior approval.

5. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California.

6. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

7. Respondent shall comply with the Division's probation surveillance program.

8. Respondent shall appear in person for interviews with the Division's medical consultant upon request at various intervals and with reasonable notice.

9. In the event respondent should leave California to reside or to practice outside the State, respondent must notify in writing the Division of the dates of departure and

return. Periods of residency or practice outside California will not apply to the reduction of this probationary period.

If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may set aside the stay order and impose the revocation of the respondent's certificate.

Upon successful completion of probation, respondent's certificate will be fully restored.

This decision becomes effective on November 7, 1979.

SO ORDERED October 8, 1979.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By [signature] MD.
A. DAVID AXELRAD, M.D.
Secretary-Treasurer

FL:jw

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KENT S. TAYLOR, M.D. Respondent.	NO. D-2113 N-10814

NOTICE OF NON-ADOPTION OF PROPOSED DECISION

(Pursuant to Section 11517 of the Government Code)

TO THE RESPONDENT ABOVE NAMED:

YOU ARE HEREBY NOTIFIED that the Division of Medical Quality of the Board of Medical Quality Assurance of the State of California has decided not to adopt the attached proposed decision rendered by a panel of a Medical Quality Review Committee. You are also notified that the Division of Medical Quality will decide the case upon the record, including the transcript and without the taking of additional evidence. You are hereby afforded the opportunity to present written argument to the Division of Medical Quality, if you desire to do so, by filing such written argument with the Division at its office at 1430 Howe Avenue, Sacramento, California 95825, and the same opportunity is afforded the Attorney General of the State of California.

You will be notified of the date for submission of such written argument when the transcript of the administrative hearing becomes available.

DATED: September 21, 1978

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

Vernon A. Leeper

VERNON A. LEEPER, Program Manager
Enforcement Unit

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
KENT S. TAYLOR, M.D. 131 Crespi Exeter, CA 93221 License No. A-11265	)	NO. D-2113 N-10814
Respondent.	)	

PROPOSED DECISION

The matter came on for hearing May 22, 23 and 25, 1978 in Fresno. A quorum of Panel 2 of the Medical Quality Review Committee of the Ninth District was present, consisting of Hugo R. Escobar, M.D., Maria E. Diaz, R.N., Hubert E. Chandler, M.D., and Donald R. Rowe, public member. Philip J. Hanley, an Administrative Law Judge of the Office of Administrative Hearings, presided.

Robert C. Cross, Deputy Attorney General, represented the complainant. Gerald J. Maglio, Attorney-at-Law, Fresno represented Kent S. Taylor, M.D. Dr. Taylor was present throughout the hearing.

Evidence was received and the matter was argued and thereafter submitted. After deliberation, the members of Panel 2 certify this decision and recommend its adoption.

FINDINGS OF FACT

I

Complainant Robert Rowland is the Executive Director of the Board of Medical Quality Assurance of the State of California. Rowland filed the accusation in his official capacity.

II

In November 1945 respondent Kent S. Taylor was issued physician and surgeon certificate No. A-11265 by the Board. The license since has been effective.

III

During 1976, in the course of his obstetrical practice, respondent Taylor committed acts of gross negligence, and acts or omissions of incompetence in his treatment and care of four women patients. The incidents took place in Exeter Hospital and in one instance in respondent's professional offices. Instances and patients are set out in the following findings.

IV

In October, 1976 Shirley W. was a patient of respondent Taylor. She was pregnant with her last menstrual period about July 15, 1976. She reported vaginal bleeding and some cramps to respondent. She was hospitalized the morning of October 15. Respondent diagnosed an "inevitable abortion" and scheduled the patient for dilation and curettage.

The patient had passed the fetus before she went to the hospital. That fact was unknown to respondent. Some months prior, respondent had performed a similar procedure on another patient. He did not remove all substances at that time. That earlier patient had to be re-admitted to the hospital within a few days for completion of the curettage.

When he was unable to remove expected products of conception from Shirley W., respondent recalled the earlier case. There was no board certified obstetrician on the Exeter Hospital staff available to respondent for consultation. He called a specialist in Fresno. The Fresno obstetrician told respondent he had evidently missed the fetus and to try again.

Respondent scraped too vigorously and perforated the uterus of Shirley W. He failed to recognize what he had done. Intent on completing the curettage, he pulled out the left ovary and a four cm. section of the Fallopian tube. Respondent was not aware of the nature of the problem. He called in a surgeon for consultation. Respondent told the surgeon of his inability to remove the fetus. The surgeon, after consent by the patient's husband, performed a hysterectomy. The patient's recovery was uneventful.

Respondent's failure to realize that he had perforated the patient's uterus is found to be incompetence.

Removal of the ovary and section of the Fallopian tube is found to be gross negligence.

Respondent's continuation of the procedure when he did not realize what he had done, what confronted him, or what he was doing is found to be gross negligence.

IV

In September, 1976 one Rosie J. was a patient of respondent's and was pregnant. The patient was 19 years old and the pregnancy was her first. Despite respondent's counsel to keep her weight down, the patient went from 206 pounds to 246 pounds during the course of her pregnancy. The patient was 5'5" in height. The expected date of delivery was late August. The patient came to respondent's office about 10:00 a.m. on the morning of September 7, 1976. He found the membranes protruding and he broke the amniotic sac while the patient was in his office.

The respondent said he determined the fetal head was snug in the cervix. He did not hospitalize the patient because she had to go home to get her things. The patient was admitted to the hospital September 8 during morning hours. September 8, 1976 was a Wednesday. Respondent did not see the patient that day. A colleague in the same professional clinic looked in on the patient about 7:00 p.m. on September 8. Respondent saw the patient about 8:35 a.m. on September 9. Labor had not progressed satisfactorily and a caesarean section was performed by respondent at 1:35 p.m. on September 9. An apparently lifeless 12 pound infant was delivered but was resuscitated by the anaestheologist.

There was a foul odor attendant on the birth, and circumstances, including a WBC of 19,600, indicated infection. The child was removed to Visalia and later to Fresno and was saved. The patient Rosie J. was administered antibiotics after midnight. The medications were neither sufficient, nor administered frequently enough.

The patient Rosie J. died September 22, 1976. Respondent had not diagnosed amnionitis. Indicated tests were not done.

The following are acts or omissions constituting gross negligence:

1. Performing the amniotomy in respondent's office.

2. Not admitting the patient immediately to the hospital but allowing her to go home.

3. Failure to manage the patient from September 7 at 10:00 a.m. until 8:35 a.m. on September 9.

4. Delay of the caesarean from September 7 until 1:30 p.m. September 9, an interval of 51 hours.

Following are acts of incompetence:

1. Failure to diagnose amnionitis.

2. Failure to administer antibiotics in sufficient quantities and of proper types.

3. Failure to timely order culture and sensitivities studies.

V

A third patient of respondent was Mary R. Her pregnancy was her third. She went to the hospital in the early morning of September 4, 1976. Respondent arrived about an hour after the patient was admitted. There was considerable delay in delivering the head of the baby. The fetus presented a problem of shoulder dystocia. In an effort to effect delivery, respondent gave the patient 5 units of pitocin. Two nurses pressed on the fundus. The baby was delivered dead.

Use of pitocin in such circumstance and in such amount was contra-indicated. Pitocin in such amount would cause a severe contraction of the uterus, possibly rupturing it, and would cause anoxia to the fetus.

Administration of pitocin to the patient Mary R. was an act of incompetence.

VI

Sadie T. was a patient of respondent's in Exeter Hospital on September 20, 1976. Respondent gave the patient pitocin buccally on that date. Administration of pitocin in the cheek has not been accepted practice for years because the absorption rate by the patient cannot be measured accurately.

Administration of pitocin to Sadie T. on September 20, 1976 was incompetence.

VII

In 1975 Karen P. was a patient of respondent's. She was a Rh Negative. She was delivered of a baby with an Rh Positive factor. Respondent did not offer RhoGAM to the patient. RhoGAM is a solution which is used to prevent the formation of active antibodies in potentially dangerous Rh cases. The patient's blood type and history, however, minimized the Rh problem. Respondent testified the practice in Exeter Hospital was for a nurse to inform the mother of any potential problem and the availability of RhoGAM.

Failure to offer RhoGAM was negligence, but not gross negligence.

VIII

No evidence was received concerning patients Mary G. and Gaudalupe G. mentioned in the accusation.

IX

With respect to substantive findings above, gross negligence is defined as an extreme departure from the standard of the practice of medicine. Incompetence is lack of knowledge or ability in discharging professional medical obligations.

* * * * *

Respondent Taylor is 64 years of age. During his youth and young manhood he was interested in medicine but because of lack of money was unable to finish medical school until 1945. He completed his medical course at Loma Linda in Southern California and thereafter interned at White Hospital in Los Angeles.

Dr. Taylor worked for the Veterans Administration from 1946-1948 and thereafter practiced two years in Lake County in Northern California. He practiced in Hollister from 1960 to 1965. Dr. Taylor is interested in, and had done, medical missionary work. He moved from Hollister to Arroyo Grande partly because of his church affiliation. He remained in Arroyo Grande until 1971.

Respondent Taylor met a doctor who practiced in Exeter and who was also interested in medical missionary work. Dr. Taylor moved to Exeter in the hope that a group or clinic could be established by four or five doctors with similar interests. One could spell another during an absence for missionary activities.

Dr. Taylor has put in tours of various lengths in missionary work in Costa Rica, Nigeria, Penang and Mexico.

Dr. Taylor estimated that he had done one hundred or more dilations and curettages up to 1976 without incident. He delivered some 150 babies in the period 1970 - 1976 (before the matters at issue herein) with only a reasonable percentage of complications.

Respondent Taylor is one of four doctors in a clinic. Custom had been to share obstetrical work, but practical factors of insurance costs dictated about 1975 that one doctor take over that field of practice. Respondent did not volunteer for obstetrics, but he took over when his colleagues voiced other preferences. Dr. Taylor is a general practitioner. There was no specialist in obstetrics available to his group or to Exeter Hospital. A Fresno specialist would consult when he was available by telephone. Respondent testified he did what he felt was proper, that he asked for assistance and consultations when indicated but that inability to receive expert obstetrical advice was a significant factor.

Respondent is married. His wife is an R.N. as are his two daughters. His son attends college. Respondent is well regarded personally and professionally in the community in which he lives and in the areas where he formerly practiced. Respondent resigned his obstetrical and surgical privileges in late 1976 at the suggestion of the hospital administration. He applied for restoration in 1977, was given limited privileges of simple obstetrics, assisting at surgery and care of medical patients.

DETERMINATION OF ISSUES

I

Allegations of the accusation concerning patients Mary G. and Guadalupe G. in Paragraph VI sub-sections 2 and 6 are dismissed for lack of evidence.

II

Evidence concerning Karen P. establishes negligence but not gross negligence or incompetence and the allegation contained in Paragraph VI sub-section 7 is dismissed.

III

Respondent is guilty of gross negligence and incompetence with respect to patient Shirley W. and his license is therefore subject to discipline pursuant to Sections 2360 and 2361, Business and Professions Code.

IV

Respondent is guilty of gross negligence and incompetence with respect to patient Rosie J. and his license is therefore subject to discipline pursuant to Sections 2360 and 2361, Business and Professions Code.

V

Respondent is guilty of incompetence with respect to patient Mary R. and his license is therefore subject to discipline pursuant to Sections 2360 and 2361, Business and Professions Code.

VI

Respondent is guilty of incompetence with respect to patient Sadie T. and his license is therefore subject to discipline pursuant to Sections 2360 and 2361, Business and Professions Code.

ORDER

I. Allegations concerning Mary G., Guadlupe G. and Karen P. are dismissed.

II. For findings and determinations constituting cause for discipline, License No. A-11265 issued to respondent Kent S. Taylor is revoked. The order of revocation is made for all such causes of discipline and for each of them.

III. Revocation of the license is stayed for five years on following terms and conditions:

1. Respondent shall not practice obstetrics and shall not practice surgery.

2. Respondent shall obey all federal, state and local laws, and particularly all laws and rules governing the practice of medicine in California.

3. Respondent shall appear in person for any interviews or meetings called by the Division's medical consultant, and shall submit such reports as may be required of him by the medical consultant.

4. If respondent violates probation in any respect, the Division may set aside the stay and carry out the order of revocation, after first giving the respondent notice and opportunity to be heard.

Dated: June 23, 1978

D Rowe

DONALD R. ROWE, P.M., Chairman
Hearing Panel 2
Medical Quality Review Committee
Ninth District

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BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KENT S. TAYLOR, M.D. License No. A-11265 Respondent.	NO. D-2113 ACCUSATION

COMES NOW, the Complainant, Robert Rowland, and as a cause for disciplinary action alleges as follows:

I

Complainant Robert Rowland is the Executive Director of the Board of Medical Quality Assurance of the State of California (hereinafter referred to as "board").

II

On or about November 26, 1945, respondent Kent S. Taylor was issued physician and surgeon certificate #A-11265 by the board. At all times herein mentioned, said license was and is in full force and effect.

III

Business and Professions Code section 2360 (all future code references are to the Business and Professions Code unless otherwise specified) provides that every medical certificate issued may be suspended or revoked.

/ / / /

IV

Section 2372 provides that the holder of a medical certificate whose default has been entered, or who has been found guilty following a hearing, may have his certificate revoked, suspended for up to one year, placed on probation, or have such other disciplinary action taken against him as is deemed proper.

V

Section 2361 provides that the Division of Medical Quality shall take action against any holder of a certificate who is guilty of unprofessional conduct. Section 2361 (a) and section 2361 (b), respectively, define gross negligence and imcompetence as unprofessional conduct.

VI

Respondent Kent S. Taylor, M.D., has committed acts of gross negligence in the following particulars and is subject to disciplinary action pursuant to section 2361 (b):

1. Patient: Shirley W.
   Exeter Hospital No.: 42327
   Admission Date: 10/15/76
   Discharge Date: 10/19/76

   Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and performed a dilation and curettage on the patient in a grossly negligent manner.

2. Patient: Mary G.
   Exeter Hospital No.: 41163
   Admission Date: 4/1/76
   Discharge Date: 4/3/76

   Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and performed a dilation and curettage on the patient in a grossly negligent manner.

/ / / /

3. Patient: Rosie J.
Exeter Hospital No.: 42073
Admission Date: 9/8/76
Discharge Date: 9/22/76

Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and performed an amniotomy upon the patient and managed the patient's subsequent infection in a grossly negligent manner. As a result, the patient died.

4. Patient: Sadie T.
Exeter Hospital No.: 42468
Admission Date: 9/20/76
Discharge Date: 9/23/76

Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and medicated patient with the drug oxytocin in a grossly negligent manner.

5. Patient: Mary R.
Exeter Hospital No.: 42048
Admission Date: 9/4/76
Discharge Date: 9/8/76

Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and medicated the patient with the drug oxytocin in a grossly negligent manner.

6. Patient: Guadalupe G.
Exeter Hospital No.: 42011
Admission Date: 8/28/76
Discharge Date: 8/31/76

Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and in a grossly negligent manner failed to recognize the significance of the patient's bleeding problems.

7. Patient: Karen P.
Exeter Hospital No.: 40341
Admission Date: Unknown
Discharge Date: Unknown

Respondent treated, diagnosed, and cared for the patient in a grossly negligent manner and withheld the drug Rhogam from the patient in a grossly negligent manner.

VII

Respondent is guilty of incompetence and is therefore subject to disciplinary action pursuant to section 2361 (c). The actions evidencing the respondent's incompetence are set forth in the preceding paragraph.

WHEREFORE, Complainant prays that the Division of Medical Quality hold a hearing on the matters alleged herein and following the hearing, issue a decision:

1. Revoking or suspending the certificate of respondent;

2. Taking such other and further action as the board deems necessary and proper.

DATED: This 20th day of DECEMBER, 1977.

Robert Rowland

ROBERT ROWLAND
Executive Director
Division of Medical Quality
Board of Medical Quality Assurance
Department of Consumer Affairs
State of California